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Acute Intestinal Obstruction: The roentgenogram will give adequate data on the incomplete type of intestinal obstruction, and it is particularly in this type that the duodenal tube and Miller-Abbott tube are most useful. Because most cases of this type of intestinal obstruction occur in the postoperative period while the patient is hospitalized, incomplete intestinal obstruction is very frequently combatted successfully by conservative measures. On the other hand, complete intestinal obstruction usually occurs weeks, months, or years after a previous operation. In this type, the offending agent is generally a fibrous band which often obstructs a small area of bowel and gives the impression that one is dealing with an open-loop intestinal obstruction. It is in this particular group that fatalities occur. The roentgenogram may be misleading, and the clinical findings often do not indicate the presence of strangulation until very late in the period. Case 126 in this series is an excellent example. In this patient, the adhesive band caused what appeared to be an open-loop intestinal obstruction, and after a period of 4 days of conservative treatment, the bowel perforated several inches proximally to the obstructing agent, producing diffuse peritonitis. There were not the usual symptoms or signs of strangulation in this case. The only clue which led to a prompt surgical diagnosis was the rapid rise in the leukocyte count to 22,000. This patient was operated upon with recovery because of the early recognition of the perforation. This case also emphasizes the destructive power of increased intraluminal pressure. The sustained pressure over a period of days was sufficient to produce a focal necrosis.

In other cases in which the adhesive band plays a very important part, and in which the classical symptoms of strangulated obstruction are lacking, the author and co-workers have frequently encountered a local area of gangrene 2 cm. in diameter with actual necrosis and severance of the bowel wall, except for the mucous membrane. Protracted suction in these cases only leads to disaster and fatality.

The symptoms of strangulated intestinal obstruction are initial colicky pain, either with or without distention, depending upon the site of the obstruction; the presence of tenderness and rebound tenderness; and a leukocytosis which may vary from 12,000 to 20,000. The 2 symptoms of prime importance in the recognition of strangulated intestinal obstruction are tenderness and rebound tenderness, indicative of local peritonitis. There is an exception to this rule. Strangulated obstruction can exist without tenderness and rebound tenderness, and this is particularly true in cases of intussusception.

The disastrous type of case that is encountered is the closed-loop strangulated intestinal obstruction. In the author's experience, this is most commonly caused by an adhesive band beneath which a loop of bowel is imprisoned. The



colicky pain is severe. Early tenderness and rebound tenderness exist because of infarction caused by the cutting off first of the venous blood, and subsequently of the arterial blood, causing the associated local peritonitis. There seems to be little excuse for attempting to treat these patients conservatively. Case 180 from the author's series represents an example of this problem. The patient was treated with morphine and intraduodenal suction for 3 days. It was not until the patient was moribund that a surgical consultation was requested. Case 112 is of an additional patient who was treated medically for 72 hours. This patient finally developed tetany. A neurologist, called in consultation, made the diagnosis of intestinal obstruction. This patient had all of the classical symptoms for 72 hours. In contrast with these 2 pathetic cases, the patient in case 212 was admitted in emergency with colicky pain, vomiting, and some distention. She had been ill for 14 hours. A flat plate of the abdomen showed intestinal obstruction. There was definite evidence of strangulation (tenderness, rebound tenderness, fever, and leukocytosis). The patient was operated upon within 2 hours, after correction of fluid and electrolyte imbalance and administration of antibiotics. At operation, she had a volvulus of the small intestine which required resection of 18 feet of gangrenous bowel. In further contrast, this patient made an uneventful recovery.

Most of the errors of the author and co-workers have occurred in cases of vascular obstruction. A 56-year-old man, case 217, was ill for 3 days with abdominal pain. Morphine was administered by his family physician during this period. Scout films of the abdomen revealed a small area of what appeared to be intestinal obstruction. The diagnosis of mesenteric thrombosis was missed and should not have been because this man gave a typical history of passing blood by bowel 2 days prior to his admission. He was operated upon as an abdominal emergency and several feet of small bowel were successfully resected. This patient had tenderness and rebound tenderness, without leukocytosis, and these signs together with moderate distention and the passage of blood should have been sufficient to diagnose the case. Case 207 illustrates another wrong diagnosis and one which is important to mention. Three months previously the patient had had a gastro-intestinal hemorrhage with symptoms of profound collapse, anemia, and the passage of bloody stools. At that time a tentative diagnosis of bleeding peptic ulcer was made and he was transfused promptly with one liter of blood. One week following his admission roentgenologic study failed to disclose any evidence of peptic ulcer. In view of the negative roentgenographic findings, the patient was discharged in the care of a gastro-enterologist. Six weeks later he was readmitted to the hospital with abdominal pain and distention, particularly marked on the left side above the umbilicus. Flat roentgen films showed several feet of distended bowel, and the diagnosis of intestinal obstruction was made. His electrolyte and fluid imbalance were corrected, antibiotics were administered, and a duodenal



suction tube was introduced. At operation he had edema of the bowel and its mesentery, with cyanosis and cord-like thickening of all the venous radicals, indicated by a bluish-black discoloration of the blood in this portion of the bowel in contrast with that in the adjacent bowel. The arterial supply was excellent. A diagnosis of venous mesenteric thrombosis was made. Because knowledge of the cause of venous mesenteric thrombosis indicates that this lesion usually occurs as a secondary manifestation particularly in biliary tract disease, that region was explored. It was found that the patient had a fistula between the gallbladder and the duodenum, with a large stone in the gallbladder and stones in the common bile duct. The gallbladder was removed, the fistula repaired, the common duct stones removed, and T-tube drainage instituted. This patient made an uneventful convalescence, and subsequent roentgenologic study showed that the bowel had returned to normal.

The greatest obstacle in delayed operation for intestinal obstruction is distention. Having passed through the period of years before the use of the Wangensteen and Miller-Abbott tubes, and having experienced the high mortality which existed then, the author and co-workers have been fearful of delaying surgical procedure until marked distention is present. Although it is true that Doctor Wangensteen has devised a most ingenious method of aseptically decompressing the bowel on the operating table, the author's belief is that operation should be done before marked distention occurs, and the Wangensteen method should only be used when the patient comes to the surgeon with marked distention.

The author prefers to follow McKittrick's plan which consists of decompression until electrolyte and fluid balance are achieved and antibiotics are administered, and then institution of surgical measures. The reason for reaching this conclusion was the failure of duodenal suction by the Wangensteen method to combat distention in low intestinal obstruction. The Miller-Abbott tube which replaced the duodenal tube was equally unsatisfactory, requiring from 24 to 48 hours before it reached the site of the low obstruction. Although it is true that there have been some improvements in the Miller-Abbott tube to cut down this period, the author and co-workers have not experienced this gainful time, and have therefore abandoned it in cases in which strangulation obstruction is obvious or even suspected.

Case 184, in which there was local gangrene produced by an adhesive band, is an excellent example of the danger involved in delaying surgery while relying upon medical care with Miller-Abbott tube decompression. When the Miller-Abbott tube finally reached the site of obstruction and x-ray examination showed the closed-loop obstruction present, this patient had strangulation and gangrene. In spite of resection he died of a toxemia 3 weeks later.



The striking decrease in mortality that has occurred during the past 15 years in a series of 225 cases of acute intestinal obstruction is attributable to (1) the use of continuous spinal anesthesia in elderly patients, (2) pre-operative correction of fluid and electrolyte imbalance, (3) the use of antibiotics, and (4) early operation, using duodenal suction or Miller-Abbott tube decompression as adjuncts rather than definitive therapy.

It is easier to prevent than to cure; early operation minimizes the risks of embarrassing distention, strangulation, and necrosis of the bowel. (Post-graduate Med., March '50, T. A. Shallow)

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Use of Anticoagulant (Dicoumarol) in Preventing Postirradiation Tissue Changes in the Human Lung: It has been shown by Kaplan and Etkin in cases of carcinoma of the lung that the delivery of from 5500 to 6500 roentgens to the tumor within a period of from 4 to 5 weeks was sufficient completely to destroy the tumor. In order to attain this cancerocidal dose at the tumor level it was necessary to employ a multiple portal technic. In spite of complete tumor destruction (proved at autopsy) death occurred shortly in 3 out of 4 of Kaplan and Etkin's cases as a result of radiation changes in the lungs.

The obvious problem is to eliminate the paradox of successful treatment of the tumor with ultimate death of the patient as a result of secondary changes induced by the treatment itself.

Boys and Harris were able to demonstrate a marked diminution of both gross and microscopic pulmonary changes resulting from irradiation in heparinized rabbits.

It seemed reasonable by the use of anticoagulant therapy to attempt to prevent in human beings the inflammatory changes and fibrin production within the lungs, which result in fibrosis, and also to prevent thromboses and fibrosis within the smaller blood vessels of the lungs.

The first patient did not survive long enough to enable evaluation of the ultimate effects following a full course of roentgen therapy for his carcinoma of the esophagus, but certain features were encouraging; although the tumor was almost completely eradicated after having received only one half of the optimal dosage, both gross and microscopic examination of the lungs failed to reveal any changes which could be attributed to irradiation.

Because of the economic and other considerations involved in maintaining a suitably increased prothrombin time over a period of weeks, dicoumarol



was chosen instead of heparin. The use of a long-acting anticoagulant such as "Depo-heparin" (Upjohn) may prove even more advantageous in spite of the cost of such material. The modified Quick technic was employed using a commercially prepared thromboplastin. An attempt to maintain the prothrombin level between 10 and 30 percent of normal was made.

Since the submission of the first case report, 2 additional patients with cancer of the esophagus and 6 patients with cancer of the lung have been treated while under dicoumarol coverage beginning before and ending after the course of roentgen irradiation. Each of the patients with carcinoma of the esophagus received a tumor dose of 6000 r. Repeated roentgen examination of the esophagus of each of these patients showed a marked response to the irradiation with almost complete healing of the lesions. Roentgenographically, the mucosa of the esophagus returned to normal, but there was some residual stenosis presented in each case. In spite of this, the patients were able to swallow foods without difficulty. Careful examination of the follow-up films showed no evidence of irradiation reaction in the lung fields. Both patients died after discharge from the hospital and autopsies were not obtained. The 6 patients with cancer of the lung, all of whom were inoperable, received from 5000 to 8000 r. These patients were treated through multiple portals ranging from a minimum of 7 fields in one case to 12 fields in another but averaging about 10 fields per case. The total skin dose averaged between 20,000 and 22,000 r. over 10 fields. Five of these patients died of metastatic spread within from one to 3 months after the completion of therapy. They did not show any roentgenographic evidence of radiation pneumonitis at any time during or after the course of therapy. All patients showed a definite decrease in the size of the tumor. Three patients came to autopsy. The sixth patient is still alive and is in an improved condition one month after completion of therapy.

One patient with cancer of the lung was treated in a similar manner with administration of 5133 r. into the tumor. However, this patient was not given dicoumarol. During the course of irradiation, the patient developed a radiation pneumonitis and later at autopsy there was gross and microscopic evidence of pulmonary fibrosis and obliterative fibrous pleuritis attributable to the roentgen therapy.

Certain conclusions have been reached from the experience gained in treating these patients. (1) It is the general impression of the authors that the administration of dicoumarol will prevent radiation reaction in normal lung tissue up to the limits of skin tolerance; actually, radiation administered through a portal even beyond the point of skin breakdown produces no microscopic evidence of radiation reaction in normal lung under the center of the portal. (2) Patients with carcinoma of the esophagus, both early and late, for whom surgery has nothing to offer and those patients who refuse surgery, have a lesion which will respond to 5000 r. delivered at the tumor. Therefore, this type of therapy



should be employed in such cases, preferably using dicoumarol. (3) Cancer of the lung is much more resistant than cancer of the esophagus. In all of the cases studied, viable-appearing tumor cells have been found present even though as much as 8000 r. have been administered to the tumor. The administration of such large doses should be reserved only for those selected few patients who have relatively early cancer but for some reason may not have the benefit of surgery. The patients with hopeless cases who show definite evidence of metastases to the ribs or other organs should not be subjected to massive doses of radiation but should receive only palliative therapy. Every patient in this group, all of whom were hopeless and inoperable, received marked relief from distressing symptoms of cough, hemoptysis and pain, after the first two weeks of therapy. (4) Patients given dicoumarol at the same time as they receive roentgen therapy are extremely difficult to maintain on a constant prothrombin level. Unpredictable responses to relatively small amounts of dicoumarol have been observed. In other cases, massive doses of dicoumarol have been needed to lengthen the prothrombin time. Patients receiving this type of therapy should be under careful observation in a hospital during the entire course of therapy. The reactions of dicoumarolized patients receiving roentgen therapy will be the subject of a subsequent paper. (Am. J. Roentgenol., March '50, S. H. Macht and H. Perlberg, Jr.)

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Efficacy of Testosterone Compounds Administered Sublingually: The androgenic effects of buccal tablets of testosterone, testosterone propionate, and methyltestosterone were assayed in 12 hypogonadal men by R. F. Escamilla and G. S. Gordon working in the Endocrine Clinic of the Division of Medicine, University of California Medical School, San Francisco. In 7 of the patients, treatment with tablets under the tongue or in the buccal gutter was the initial androgenic therapy. The other 5 had previously received parenteral androgens, but treatment had lapsed before the start of this study in 3 cases. Various preparations were compared serially in the same patient, and the degree of androgenic effect tabulated.

When administered as buccal or sublingual tablets, methyltestosterone was approximately twice as potent per milligram as unesterized testosterone, which in turn was approximately twice as potent as testosterone propionate. Failures to initiate or to maintain an androgenic effect were not encountered with methyltestosterone, but occasionally were found with the other 2 preparations. The type of base or the place in the buccal cavity in which the tablets were dissolved did not seem to alter the clinical effectiveness to any important degree. The gelatin-sucrose base seemed occasionally slightly superior to the lactose base or the wax base as a vehicle for unesterized testosterone. Hard compressed tablets designed for slow dissolution appear to be essential for full effectiveness by this route. In this series of hypogonadal men, 10 mg. of methyltestosterone per day administered as a buccal or sublingual tablet was usually a full maintenance dose. (J. Clin. Endocrinol., Feb. '50)

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Jaundice During Methyltestosterone Therapy: Jaundice with distinctive features has been reported as occurring during the course of orally administered methyltestosterone. Evidence has been gradually accumulated to indicate that methyltestosterone itself may cause jaundice. Six patients have been seen from 1942 to date at the Presbyterian Hospital, 2 within the past 6 months. Five of the patients are men and one is a woman. Their ages range from 17 to 67 years. Five of the 6 patients at the Presbyterian Hospital received methyltestosterone pills (Schering) by mouth. The sixth was given methyltestosterone linguets (Ciba) sublingually. Dosage schedules ranged from 10 mg. twice daily sublingually to 20 mg. 4 times a day by mouth. An additional patient from Billings Hospital treated by another physician received from 25 to 50 mg. orally daily. Five of the 6 patients in the Presbyterian Hospital series took the drug for from 3 to 4 months before toxic manifestations appeared. The sixth, the woman, took the drug for only 8 days. The patient from Billings Hospital had received the drug for 4 months before becoming jaundiced. Premonitory symptoms consisted of nausea, malaise, and vague gastro-intestinal symptoms which usually began about one or 2 weeks before jaundice was observed. There was no history of preceding upper respiratory infection or of contact with cases of hepatitis. None had received blood or plasma transfusions or had been exposed to any known hepatotoxic agent. The degree of jaundice was uniformly intense. The liver was palpable in 4 of the 7 patients, was firm but not tender. Itching was notable in only one case. The duration of jaundice was protracted. An elevated serum bilirubin persisted for from 3 weeks to 3 months. Only one patient in the series showed evidence of severe hepatic dysfunction. Recovery was ultimately complete and apparently without residual liver injury in the 2 patients available for long-term follow-up.

The uniformity of laboratory findings and the details of the histologic picture in liver biopsies indicate what is considered to be a characteristic type of hepatic injury. The outstanding feature is apparently a stasis, with an accumulation of bile within the bile capillaries of the central portion of the lobule, with no evidence of obstruction in the larger bile ducts. The phenomenon is associated with a derangement of contiguous hepatic cells which despite minor histologic alterations remain viable and do not invoke a positive cephalin-flocculation reaction. Various metabolic activities of the hepatic cells, especially the function of maintenance of the cholesterol-to-cholesterol-ester ratio in the serum, may show moderate impairment but the most striking functional disturbance is the failure to maintain the excretion of bilirubin and the flow of bile through the terminal biliary radicles. The cause of the bile stasis has not been determined with certainty. The absence of lesions in the portal triads or swelling of the bile ducts differentiates the jaundice following testosterone from the intrahepatic obstructive jaundice resulting from cholangiolitis which has been described following administration of arsphenamine and other drugs. No coagulable fibrin-like matrix could be demonstrated in the bile plugs to explain their formation. It is not improbable that injury to the hepatic cells by the drug leads to a disturbance of the normal hydration of the bile which becomes too viscous to flow through the intralobular duct system.



It is noteworthy that the hepatic lesion found in methyltestosterone intoxication gives rise to a clinical picture in which jaundice of conspicuous intensity occurs without the characteristic features of either severe parenchymal damage usually marked by a positive cephalin-flocculation reaction and striking disturbances of metabolic function or of biliary obstruction such as a definite elevation of alkaline phosphatase and of total cholesterol in the serum.

The evidence that methyltestosterone is the causative agent for the disorder is indirect. Intercurrent infectious hepatitis seems ruled out on both clinical and histologic grounds. Rarely cases of hepatitis are encountered which show chemical features similar to those described; however, inflammatory changes are usually demonstrable in the liver. The vehicles for the methyltestosterone have not been the same in all instances, are innocuous and would therefore seem of little etiologic significance.

It seems improbable that methyltestosterone is a markedly hepatotoxic agent because the syndrome described is rare despite widespread usage of the hormone. A drug sensitization or a personal idiosyncrasy might be assumed but this possibility must be accepted with caution in view of the failure of the 2 patients re-treated at the Presbyterian Hospital to redevelop jaundice when the drug was resumed. Overdosage with the hormone also seems unlikely because as little as 20 mg. a day was sufficient to produce the difficulty in one instance. (Am. J. Medicine, March '50, S. C. Werner et al.)

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Death of Cesarean Infants: A Theory as to Its Cause and a Method of Prevention: The deaths of 2 infants delivered by cesarean section in the summer of 1946 stimulated the authors' interest in the problem of the cesarean infant. In their experience these infants have had a more stormy time than have those delivered normally.

The authors have been particularly impressed by the infants that leave the operating room in apparently good condition, but later develop cyanosis, respiratory distress with dyspnea, air hunger, and costal retraction with rapid weak pulse. They fade rapidly and die in terminal convulsions in about from 18 to 20 hours. At the first sign of distress oxygen has been started, the infants placed in incubators, and coramine, caffeine, and adrenalin given, according to the judgment of the physician. These measures seldom have been of benefit.

Based upon the experiences and beliefs of their own as well as those of other workers whose mortality figures have been almost as high as 9 percent,

the authors developed the opinion that part of the cesarean infant's difficulty might be explained by the deprivation of a considerable amount of the blood resulting from the rapidity of tying off the cord, which the baby delivered in the normal manner receives. The clinical course in the infants that develop this unfavorable reaction is similar to that of older patients in shock from blood loss.

Ballentine, from his studies of delayed clamping of the umbilical cord in newborn infants, found an average increase of 96 cc. of blood by delaying clamping until cord pulsations had ceased. De Marsh, Windle, and Alt found that immediate clamping of the cord of the newborn infant deprives the infant of 107 cc. of blood (on the average). They found that the average blood volume of those infants allowed to receive this placental and umbilical vessel blood (delayed clamping) was 361 cc. or 11.8 percent of the body weight; it was only 301 cc. or 9.6 percent of the body weight when immediate clamping of the cord was practiced. The average quantity of blood flowing freely out of the placental end of the severed cord was 107 cc. These investigators estimate that more than 26 percent, but less than 34 percent of the average total fetal blood is in the placenta and umbilical vessels at the end of fetal life. Under normal conditions of birth most of this blood passes to the newborn infant during the third stage of labor while the uterus is contracting on the placenta. These figures show that the quantity of blood that the infant receives from the placenta (from 96 to 107 cc.) looms tremendously large in relation to its total blood volume.

It occurred to the authors that the immediate clamping and cutting of the cord might be the essential point of difference between the cesarean- and the normally-delivered infant. This procedure (the immediate clamping and cutting of the cord) unquestionably deprives the infant of considerable blood and can well be the cause of the previously described delayed reaction. For this reason it was decided to change the technic of the cesarean sections to enable the infant to receive more placental blood.

The assistant designated to care for the infant is scrubbed and stands to the left of the operator. After the infant is delivered from the uterus this assistant holds the infant by the legs with the head down. The pharynx is aspirated by means of a rubber bulb syringe. The cord is neither clamped nor severed. The placenta is separated from the uterus and wrapped in a large turkish towel. Several clamps are used in order to secure the placenta because it slips out easily. The infant and the wrapped placenta connected by the intact umbilical cord are carried to an awaiting table or cart. The placenta is suspended from a standard by means of a clamp attached to the towel. The infant lies on the table wrapped in sterile cloths and warm blankets. The stimulants of choice are in readiness, as is an infant resuscitator. The cord is not cut until its blood vessels have collapsed. It is then clamped, cut, and tied in the usual manner. The placenta is usually drained and the cord collapsed in from 6 to 10 minutes.



By this technic the authors feel that the infant receives much more blood than he would were the cord cut early. In several instances the placenta was weighed before and after suspension. The average difference was 45 grams. This amount is undoubtedly conservative as the infant receives blood constantly at the operating table while he is suspended with the head down and while he and the placenta are being transported to the awaiting infant's table. On one occasion the umbilical cord was accidentally severed on opening the uterine cavity. The cord was clamped immediately. Ninety-five cubic centimeters of blood was recovered.

The authors assume that the amount of blood saved for the infant by this technic to be about 90 cc. This represents a transfusion of a considerable amount, considering the blood volume of the newborn infant to be approximately 10 percent of the body weight.

In 87 sections done since instituting this technic of placental suspension and drainage, there have been no instances of the previously described syndrome. The running of a control series has not seemed justified. One infant delivered by cesarean section from a mother with far-advanced tuberculosis died several hours later without any of the symptoms of shock. This child's condition had not been good at any time. Death was thought to be a result of prematurity and to the influence of the mother's toxic condition. There was one other death on the fourth day from atelectasis.

The infants delivered since using this technic have impressed the authors as being more active sooner than the average section infant. They are ruddy in color. There have been few neonatal upsets.

This series includes one premature infant delivered by section because of placenta previa. This child survived. One other premature infant was delivered by section because of uteroplacental apoplexy. This child also survived.

The authors feel that this procedure is especially valuable for premature infants. Just as delayed ligation of the umbilical cord is important to the premature infant in normal delivery, the authors feel that the procedure of placental suspension and drainage is likewise important to the premature infant in cesarean section. Because the placenta is larger in relation to body size in the premature than in the mature baby, the quantity of the placental blood is greater in relation to the premature infant's blood volume. The premature infants in this series have done well. It is planned to make a more complete report on the premature group of infants later.

The authors have been impressed by the resemblance between this syndrome of the cesarean infant and that of hematogenic shock in the older patient. Common points of similarity include accelerated weak pulse, subnormal temperature, the presence of dyspnea, cyanosis, and vomiting. It has not been

possible to determine blood pressures, blood volumes, and circulation times on these infants. (J. Pediat., April '50, D. B. Landau et al.)

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Physical Activity and Paralysis in Poliomyelitis: The relation between physical activity and the subsequent development of paralysis in anterior poliomyelitis is of both practical and theoretical importance. There has been an impression for many years that severe paralysis may be precipitated by strenuous activity in the preparalytic stage of the disease, but Ritchie Russell was the first to gather reliable evidence on this point. He studied 44 patients in the 1947 epidemic in England, obtaining detailed histories of their early symptoms and of their activities after the onset of symptoms and in the 3 days immediately preceding the onset. He found no correlation between physical activity in the 3 days before the onset and the degree of the subsequent paralysis, but showed conclusively that physical activity during the 48 hours after the onset predisposed to severe paralysis, whereas patients who rested in bed from the start of their symptoms were unlikely to develop a disabling paralysis. Subsequently he studied a further 56 cases from the same epidemic and confirmed his previous findings, and Hargreaves, after a comparable study of 30 patients, agreed with his conclusions.

In the United States, Horstmann has investigated 411 cases of poliomyelitis in the 1948 epidemic on similar lines. About 20 percent of these patients had a prodromal stage of mild fever and constitutional symptoms lasting one or 2 days and then subsiding, to be succeeded 3 or 4 days later by a rise of temperature and symptoms of the meningitic phase of the disease. She found no significant difference in the amount of physical exercise taken in this prodromal phase between those who were eventually free from paralysis or only slightly paralyzed and those who developed moderate or severe paralysis. But her findings were quite different when the meningitic stage was considered. Physical activity in the 3 days before the start of the meningitic symptoms did not seem to affect the subsequent paralysis, but any physical exertion in the 48 hours after the onset undoubtedly made the patient more likely to develop moderate or severe paralysis. The incidence of paralysis was very much lower in those who rested in bed as soon as symptoms started; and of the patients who in fact developed moderate or severe paralysis, only 9 percent had stayed in bed or taken only minimal physical exercise during the 24 hours after the onset of symptoms, whereas 74 percent had continued with their normal activities. There were 64 cases of bulbar involvement in Horstmann's series, of which 9 were only mild; but in this group, in contrast to those with spinal involvement, no correlation was found between physical activity after the onset of symptoms and the subsequent disability. Horstmann found that left-sided paralysis was more common in the 28 left-handed patients in her series than in the 186 right-handed ones.



The practical lesson to be learned from Ritchie Russell and Horstmann's studies is that patients must be confined to bed at the beginning of the pre-paralytic phase. In sporadic cases, particularly in adults, this may be impossible. But in the poliomyelitis season the aim should be to keep in bed all children with mild febrile illness accompanied by headache and muscle pains. It is generally agreed that during the preparalytic stage, virus is invading the central nervous system, and the susceptibility of the anterior horn cells to the attacks of the virus probably depends on various factors, including nutrition. It has been shown in experimental poliomyelitis in monkeys that exhausting exercise and chilling increase the incidence and severity of paralysis, and conversely that division of a peripheral nerve a few days before infection will protect the anterior horn cells associated with that nerve from damage by the virus. Thus when the poliomyelitis virus has already invaded the nervous system, one factor which increases the chances of damage to anterior horn cells is physiological activity of those cells. (Lancet, 11 March '50 - Leading Article)

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Indications for Pulmonary Resection: The variety of pulmonary lesions for which pulmonary resection has proved to be the treatment of choice has grown rapidly in recent years. The author believed that it would be of interest to review the records of a group of patients for whom pulmonary resection has been performed. He selected 100 consecutive cases in which he had performed lobectomy and 100 consecutive cases in which he had performed pneumonectomy. Pulmonary resection was performed for 19 different pathologic conditions in this series of 200 patients (table below).

Two Hundred Consecutive Pulmonary Resections

	Pneumo- nectomy	Lobec- tomy	Total	Deaths
Bronchiogenic carcinoma	48	9	57	1
Metastatic carcinoma	6	3	9	
Bronchiectasis	16	34	50	
Tuberculosis	11	18	29	1
Pulmonary abscess	5	9	14	
Bronchial cyst	1	9	10	
Broncholithiasis	1	5	6	
Indeterminate granuloma	0	4	4	
Bronchial adenoma	3	1	4	1
Bronchial stricture	3	1	4	
Emphysematous blebs	1	2	3	
Cylindroma of bronchus	2	0	2	1
Hamartoma	1	1	2	
Amyloid tumor of bronchus	1	0	1	
Coccidioidomycosis	1	0	1	
Echinococcus cyst	0	1	1	
Histoplasmosis	0	1	1	
Actinomycosis	0	1	1	
Hemangio-endothelioma	0	1	1	1
Total	100	100	200	5



Carcinoma of the Lung. The most common lesion for which resection was carried out was bronchiogenic carcinoma. The frequency with which carcinoma of the lung occurs is not appreciated generally. There is a considerable amount of evidence that indicates that there has been a marked increase in the incidence of cancer of the lung, as compared with other cancers in the body, and recent figures suggest that cancer of the lung is now the most common of all malignant growths in the body, even more common than cancer of the stomach. Bronchiogenic cancer occurs in men from 4 to 5 times as frequently as in women and usually in individuals about 40 years of age, but it can occur in individuals much younger.

The diagnosis of cancer of the lung can be established in most cases by roentgenographic examination, the history and physical examination, bronchoscopy, and cytologic study of bronchial secretions and sputum. Deep roentgen therapy has not proved effective, and the only adequate treatment at the present time is pulmonary resection.

In this series, pneumonectomy was carried out in 48 cases and lobectomy was carried out in 9 cases. The wisdom of performing lobectomy rather than pneumonectomy in some of these cases may be doubted, because the choice does violate the principle that operations for cancer should be radical operations. However, other considerations besides cure alone must be kept in mind by the surgeon. Obviously the risk of pneumonectomy and the disability that results to the patient from this operation are greater than from lobectomy. Furthermore, in some cases of cancer of the lung in which there is a peripherally placed lesion and in which frozen section examination of the hilar nodes at the time of operation shows that there is no involvement, lobectomy is a justifiable procedure, particularly if the patient has any evidence of a limited respiratory reserve.

It is important to point out that carcinoma of the lung can very closely simulate, both clinically and roentgenographically, a great variety of other pulmonary lesions. It is possible at the present time to make an accurate preoperative diagnosis of carcinoma of the lung in only about 70 percent of cases. The roentgenogram is not a pathologic diagnosis. If the bronchoscopist can give a positive diagnosis or if one can get a positive diagnosis from examination of the sputum, that is fine, but one must remember that negative reports from these examinations do not mean that the patient does not have cancer of the lung; if the patient has an indeterminate pulmonary lesion he probably needs to undergo exploration. A "look-and-see" policy in dealing with such a patient is of much greater wisdom than a "wait-and-see" policy which is so often adopted with these pulmonary lesions. The policy of waiting, watching, and taking frequent roentgenograms of pulmonary lesions is a false one. The lesions should be subjected to exploration to find out what they are.



In 9 instances pulmonary resection was performed for metastatic lesions in the lung (see table). In all of these instances it was known or strongly suspected before operation that the pulmonary lesion was metastatic. However, in the presence of a solitary metastatic lesion the author and co-workers believe, from their own experience and that reported by Alexander at the University of Michigan, that the results in such cases are encouraging enough to warrant pulmonary resection in an occasional case of pulmonary metastasis.

Bronchiectasis. Bronchiectasis is a relatively common indication for pulmonary resection. In one fourth of this series of cases resections were performed for bronchiectasis. It is interesting to note, however, that the incidence of bronchiectasis is decreasing. This can probably be accounted for by the fact that the use of chemotherapy and the antibiotics has almost eliminated the bronchial damage that results from bronchial pneumonia that formerly accompanied whooping cough, measles, scarlet fever, and the various other infectious diseases of childhood. It is also probable that the prompt bronchoscopic removal of foreign bodies from the tracheobronchial tree has prevented the development of bronchiectasis in many cases. The experience with bronchiectasis at the Mayo clinic indicates that it is becoming much less common and that in a few more years it may become relatively rare.

Pulmonary resection, however, is the treatment of choice for bronchiectasis if the lesion is sufficiently well localized to permit resection. In this group of 50 resections, pneumonectomy was performed 16 times and lobectomy 34 times. More than one lobe was removed in 21 of the 34 lobectomies. There were no deaths in this group of cases.

Tuberculosis. Only a few years ago pulmonary resection for the treatment in tuberculosis was condemned rather widely. It is true that in the early experience with this procedure the cases were poorly chosen and that the results were discouraging in many instances; obviously still, resection should not be resorted to if more conservative measures will be effective. However, it must be admitted that there are many instances in which more conservative measures are not adequate. These include particularly tuberculous bronchial strictures, tuberculomas, basal tuberculosis with or without bronchiectasis, and unilateral disease which fails to respond to adequate collapse by thoracoplasty or pneumothorax.

The development of streptomycin has been of tremendous aid in the prevention of reactivation and spread of the disease after resection. There now seems to be justification for extending cautiously the indications for resection in tuberculosis. Many patients with tuberculosis can be restored much more quickly and much more safely with resection than by resort to some of the conservative procedures that have been useful in the past.



Pulmonary Abscess. Pulmonary abscesses occur much less frequently than they used to occur. Antibiotic therapy is preventing their development in many cases, but a factor of perhaps even greater importance in reduced incidence of this lesion is that better anesthesia is now available and there is a wider appreciation of the importance of being sure, at the end of any surgical procedure, that no foreign material is retained in the tracheobronchial tree. Anesthetists now appreciate the importance of aspiration of all secretions from the tracheobronchial tree.

For the pulmonary abscesses that do occur, particularly if they have been present very long and if they occur in children, the author and co-workers feel that pulmonary resection is a better treatment than the external drainage that used to be performed. At the present time, there seem to be few indications for external drainage of pulmonary abscess. The patient gets well much quicker and much more easily after pulmonary resection than after external drainage, and resection can be done very safely. External drainage invariably leaves the patient with some residual bronchiectasis in the part of the lung involved, and often operation must be performed subsequently for the condition anyway. Primary resection is the treatment of choice in most pulmonary abscesses.

Bronchial Cyst. All bronchial cysts should be excised because they are usually infected, because they are the source of hemorrhage in many cases and because in about 10 percent of cases carcinoma will ultimately follow in the wall of the bronchial cyst. They are congenital lesions, for the most part, although occasionally it is possible that one may be acquired. As proof of their congenital nature, it is interesting to note that bronchial cysts in the lower lobe are nearly always associated with a large aberrant artery coming directly off the aorta.

Broncholithiasis. The most likely origin of this interesting lesion is the erosion of a calcified hilar lymph node through the wall of the bronchus, producing an ulceration of the bronchus, obstruction of the bronchus associated with an obstructive pneumonitis distally, and a severe cough with foul sputum and blood. In some cases the patients bled so severely that they had to be transfused. Often the patient coughs up some fragments of stone and gets relief of symptoms, but in other cases the stone remains in the bronchus and the patient goes on having symptoms. Resection is indicated if there is very much damage to the lung, even though the stone can sometimes be removed bronchoscopically.

Other Lesions. Adenomas of the bronchus are different from the usual cancer of the lung. They are low-grade cancers and they can metastasize to local lymph nodes and the liver but they do so very late. Even though these tumors are slow-growing, they should all be removed because they are



malignant lesions. An excellent prognosis can always be anticipated if they are operated upon.

The remaining types of pulmonary lesions for which pulmonary resection was performed are rather rare conditions. For the most part they were not diagnosed definitely until after pathologic examination of the resected specimen. However, the author believes that indeterminate pulmonary lesions should be removed if a diagnosis cannot be made without operation; in 114 consecutive cases of indeterminate pulmonary lesion in which operation was performed, 65 percent of the lesions proved to be carcinoma and the remainder, without exception, were lesions for which the best treatment was pulmonary resection. Because the risk of exploratory thoracotomy and pulmonary resection is so small, the author believes that this aggressive attitude is justified. In this series of 200 consecutive pulmonary resections there were only one death following lobectomy and only 4 following pneumonectomy. (Kansas City M. J., March-April '50, O. T. Clagett)

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Mortality from Syphilis: One of the objectives of the syphilis control program is to reduce the amount of disability and death resulting from syphilis. The death rate caused by syphilis has decreased from 16 per 100,000 population in 1938 to 8 in 1948. That this improvement may be attributed to control measures is shown by the fact that, although mortality from paresis started to decline in 1923 as soon as malaria therapy was introduced in the United States, deaths from other types of syphilis did not decline until after 1936, when the nation-wide venereal disease control program was initiated. The rates have been downward ever since.

Although the death rate from paresis in the nonwhite population seemed resistant for a while to control measures, particularly in the years from 1942 to 1946, later years have shown improvement, and the considerable decline is now consistent for color and sex in all types of late syphilis.

Likewise, the infant mortality rate from syphilis has declined since the initiation of the National Venereal Disease Control Program. Up to 1937 the infant mortality rate from syphilis declined at about the same rate as the infant mortality rate from all causes, but since 1938 the decline in infant mortality resulting from syphilis has been much steeper.

These mortality data are extremely encouraging and give considerable hope that mortality from syphilis will eventually be reduced to negligible proportions. Nevertheless, it is well to bear in mind that it has not yet reached that desired level. In 1948, 12,000 deaths from syphilis were recorded (not including stillbirths and abortions), of which 438 were infants under one year of age. (J. VD Information, April '50, Editorial, T. J. Bauer)

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Relationship of Blood Pressure and Weight of Recruits: In previous issues of Statistics of Navy Medicine, data were presented separately on the blood pressure readings and weights of a group of Navy and Marine Corps recruits. In this study the relationship of blood pressure and weight will be discussed. These recruits entered the naval service in September 1947 and the data used here were compiled from their physical examination records (NAVMED H-2).

The average systolic and diastolic blood pressure readings by weight groups are shown in the table below. Both the systolic and the diastolic aver-

Weight Group Pounds	Average Systolic Reading	Average Diastolic Reading
100 - 109	119.0	69.7
110 - 119	120.1	70.6
120 - 129	121.2	71.5
130 - 139	122.1	71.7
140 - 149	123.3	72.2
150 - 159	124.0	73.3
160 - 169	125.4	74.3
170 - 179	125.3	74.0
180 - 199	126.8	75.1
200 - 229	130.0	76.5

ages increased steadily with increases in weight. Approximately 93 percent of the recruits were under 20 years of age. Therefore, relatively few of them were in the ages in which elevated blood pressures are expected.

The data show that for each diastolic group the average systolic pressure increased with weight. Data were not plotted for some extreme weight groups because of small numbers.

The combined blood pressure readings were divided into 4 categories depending on whether the systolic read-

ing was above or below 135 and the diastolic pressure above or below 85. The largest group was made up of those with blood pressures of under 135 systolic and under 85 diastolic. However, this group comprised a smaller proportion of the total in each succeeding weight group. Thus among those weighing from 100 to 109 pounds this group constituted 94.5 percent of the total contrasted with only 54.9 percent of those weighing from 200 to 229 pounds. The next most frequent blood pressure group contained those with systolic readings of 135 and over and diastolic readings of 85 and under. This category assumed increasing importance with increasing weight. This relationship was also true of the remaining blood pressure group. The increasing importance of the group with systolic pressures of 135 and over and diastolic pressures of 85 and over is especially interesting. In the lowest weight group there was none with this reading. However, in the highest weight groups this category accounted for 7.8 percent of the total. (Statistics of Navy Medicine for April 1950)

\* \* \* \* \*

Clinical Memoranda on Poisoning by Pesticides: The Technical Development Services, Communicable Disease Center, U. S. Public Health Service, Savannah, Georgia, has prepared a series of clinical memoranda primarily for the guidance of physicians in treating persons poisoned by pesticides. Additional memoranda will be added or existing memoranda supplemented or revised as new information becomes available.

Each memorandum includes a brief description of the chemical nature, formulations, and uses of the compound together with medical considerations including mode of action, diagnosis and treatment. The suggestions for treatment are based on general medical principles and on animal experimentation in most instances because many of the forms of poisoning have not been observed in man.

The introduction includes suggestions for clinical tests and requests that when a study of a case of poisoning is completed, a report be sent to the Communicable Disease Center.

Distribution will be made to all district medical officers, hospitals and dispensaries. Others may obtain the memoranda at the above address. (Preventive Medicine Div., BuMed)

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Course of Instruction in Aviation Medicine: A new class in Aviation Medicine will convene at the School of Aviation Medicine, Pensacola, Florida, on 10 August 1950. The course consists of 6 months of academic instruction in aviation medicine and an additional 3 months of flight indoctrination training for those who meet all qualifications. Medical officers successfully completing the 6 months' academic course are designated aviation medical examiners. Those who qualify for and complete the additional 3 months of flight indoctrination training are designated flight surgeons. The class will be limited to 25 students and is open to medical officers of the regular Navy and Reserves of the rank of lieutenant commander and below. An agreement to remain on active duty for one year after completion of the course must be included with each application.

Aviation medicine offers diversified opportunities for naval medical experience and, hence, provides an excellent background for a career in naval medicine. Duties with aviation units afford general medical experience in addition to certain special opportunities in otolaryngology, ophthalmology, physiology, and air evacuation technics. Because aviation units are usually based in large ships or at air stations, excellent opportunities exist for experience in general medicine, surgery, and industrial medicine. Such experience forms a desirable background for those who expect ultimately to seek certification in a specialty. The special academic instruction provided at Pensacola, together with much of the experience with aviation units, is directly applicable in such specialties as otolaryngology, ophthalmology, psychiatry, and medical research. In addition, special instruction is provided in the medical aspects of atomic warfare, in the problems connected with acceleration including indoctrination



on the human centrifuge, and in the effects of flight at high altitudes. Training in the use of oxygen at high altitude and in the use of special emergency equipment is also included. The instruction given in certain basic technics in research are often highly useful in solving operational problems in the field.

Flight surgeons have made and are continuing to make definite contributions to the advances in the field of aviation.

Medical officers interested in applying for this course in aviation medicine should do so as soon as possible in order for their request to reach the Bureau of Medicine and Surgery prior to 15 June 1950. Applications may be made by dispatch up to 15 June but must be confirmed by following letter. (Professional Div., BuMed)

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Hospital Administration Course for MSC: Applications are desired from officers of the Medical Service Corps (Administrative and Supply Section) regular Navy, who are desirous of attending a course of instruction in hospital administration at the Medical Field Service School, Army Medical Center, Fort Sam Houston, Texas.

The next class which is to be of 39 weeks' duration will be convened on 4 September 1950. Requisites for attendance are that the individual officer be permanently commissioned in the Medical Service Corps (Administrative and Supply Section) of the regular Navy, and have previously completed the course of instruction at the U. S. Naval School of Hospital Administration, Bethesda, Maryland.

Requests should be addressed to the Chief, Bureau of Medicine and Surgery, Navy Department, Washington 25, D. C., attention Code 345, and must be received prior to 1 July 1950 in order to receive consideration. Requests may be made by dispatch if the time element involved indicates such action. (Professional Div., BuMed)

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Correspondence Courses Administered by the Bureau of Medicine and Surgery for Regular and Reserve Personnel: Two new courses have recently been added to the list of correspondence courses administered by the Bureau of Medicine and Surgery. The full list of these courses which are available for distribution is as follows:

<u>Medical Department Basic Courses</u>	<u>Retirement Points</u>	<u>Promotion Units</u>	<u>Eligible Personnel</u>
Medical Dept. Orientation	12	1	MC, DC, MSC, NC, HC (officers and enlisted)
Medical Dept. Administration	12	1	MC, DC, MSC, NC, HC (officers and enlisted)
Functions of Officers of the Medical Department	12	1	MC, DC, MSC, NC, HC (officers and enlisted)
<u>Medical Dept. Operations Courses</u>			
Aviation Medicine Practice	32	2-1/2	MC, DC, MSC, NC, HC (officers only)
Submarine Medicine Practice	32	2-1/2	MC, DC, MSC, NC, HC (officers only)
Combat and Field Medicine Practice	32	2-1/2	MC, DC, MSC, NC, HC (officers only)
Radiological Defense and Atomic Medicine	36	3	MC, DC, MSC, NC, HC (officers only)
Naval Preventive Medicine	36	3	MC, DC, MSC, NC, HC (officers and enlisted)
Insect, Pest and Rodent Control	32	2-1/2	MC, DC, MSC, NC, HC (officers and enlisted)
Tropical Medicine in the Field	32	2-1/2	MC, DC, MSC, NC, HC (officers only)
Physical and Psychobiological Standards & Examinations	36	3	MC, DC, MSC, NC, HC (officers only)



<u>Medical Department Operations Courses</u>	<u>Retirement Points</u>	<u>Promotion Units</u>	<u>Eligible Personnel</u>
Special Clinical Services (General)	32	2-1/2	MC, DC, MSC, NC, HC (officers and enlisted)
Special Clinical Services (Dental)	32	2-1/2	MC, DC, MSC, NC, HC (officers and enlisted)
Clinical Laboratory Procedures	36	3	MC, DC, MSC, NC, HC (officers and enlisted)

A retirement point is based on the number of hours determined to be required for the average individual to read a course. Three hours has been set as the interval unit in this respect for one point of value. Thus, a course requiring 108 hours for reading would count as 36 retirement points ( $108 \div 3 = 36$ ).

A promotion unit is based on the factor of 12 retirement points. Thus a course carrying 36 retirement points would carry also a credit of 3 promotion units ( $36 \div 12 = 3$ ).

All officers of the Medical Corps, Dental Corps, Medical Service Corps, Nurse Corps, and Hospital Corps of the regular Navy and Naval Reserve are eligible to enroll in any one of the above listed courses. Enlisted personnel of the Hospital Corps are eligible to enroll for the courses so indicated. The promotion and retirement points apply only to Reserves on inactive duty. The basic courses are required for first promotion for members of the Naval Reserve on inactive duty. (Naval interns in civilian hospitals are in an active-duty status.)

Application for enrollment should be made to the Bureau of Medicine and Surgery via appropriate official channels and may be made either on NAVPERS-992 (application for enrollment in officer's correspondence courses), or by letter request. Applications must include the full name of the applicant, rank or rate, corps, file or service number, and the address to which the material is to be forwarded.

Members of the Medical Department may enroll in only one of these courses under the sponsorship of the Bureau of Medicine and Surgery at a time. This does not preclude simultaneous enrollment in one of the correspondence courses administered by the Bureau of Naval Personnel if the individual desires to do so. Additional correspondence courses are now in process of preparation by the Bureau of Medicine and Surgery; announcement of their availability will be made later. (Reserve Div., BuMed)

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BUMED CIRCULAR LETTER 50-29

4 April 1950

From: Chief, Bureau of Medicine and Surgery  
To: All BuMed Management Control Activities  
Subj: Beneficial Suggestion Program  
Refs: (a) SecNav ltr OIR-223:aa of 10 November 1949  
(b) Navy Civilian Personnel Instruction No. 25  
(c) Article 10-16, Manual of the Medical Department  
Encl: (1) Copy of reference (a)

This letter (1) states that the Navy Department attaches great importance to the program for the submission of constructive beneficial suggestions by civilian employees and that as indicated in reference (c), it is the policy of BuMed that participation in the Navy Department Beneficial Suggestion Program be considered an integral part of the civilian personnel program in each Medical Department activity; and (2) requests that addressees furnish BuMed not later than 1 May 1950 information which may be used to review the effectiveness of this program in the Medical Department.

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BUMED CIRCULAR LETTER 50-30

5 April 1950

From: Chief, Bureau of Medicine and Surgery  
To: CO, U. S. Naval Hospitals, Continental United States  
CO, National Naval Medical Center, Bethesda, Maryland  
Subj: Civil Service Examinations for Head Maid, Chief Mess Attendant, and First Cook

This letter states that the Bureau has under consideration a proposal to secure authority from the U. S. Civil Service Commission to extend the provisions of NCPI 160.3-4 to employees in the following ratings: Head Maid, Chief Mess Attendant, and First Cook, and requests addressees to furnish BuMed with the number of such nonstatus employees now serving and whether examinations have been given for probational appointment to any of these ratings.

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From: Chief, Bureau of Medicine and Surgery  
To: All Ships and Stations having a Representative of the Medical  
Department Aboard  
Subj: Venereal Disease Contact Investigation; Renewed Emphasis on  
Adequacy of Information and Speed in Reporting

Ref: (a) NAVMED-418 (Rev. 11-45), Routing Chart for Form NAVMED-171  
(Venereal Disease Contact Report)  
(b) NAVMED-171 (Rev. 1-45), Venereal Disease Contact Report  
(c) NAVMED-P-1288, Interviewer's Aid for VD Contact Investigation

Encl: (1) Outline of Venereal Disease Contact Reporting and Routing  
System, Utilizing NAVMED-171  
(2) Mailing Addresses of City and State Health Departments

1. The National Research Council Subcommittee on Venereal Diseases recently made the following recommendation to the Armed Forces:

"That a vigorous program of tracing and of treatment of individuals of the civilian population from whom members of the Armed Forces have acquired venereal diseases be undertaken, in active collaboration with suitable agencies."

Accordingly, it is the desire of the Department of the Navy that all necessary steps be taken to improve the entire venereal disease contact reporting and investigation system. This includes improvement by the Navy in promptness and accuracy of routing, adequacy of contact-report information and diligent follow-up of all contact reports by the Health Departments to which they are forwarded.

2. In order to improve contact interviewing, the United States Public Health Service and the Virginia State Health Department have set up a special course for training hospital corpsmen in Norfolk, Virginia. It is expected that at an early date, all major naval stations will have a trained hospital corpsman for contact interviewing. A gradual shifting of these men to sea duty should materially improve contact reporting by ships. Wherever these men are fully utilized in their specialty an increased number of sexual contacts are revealed by the infected individuals and more complete epidemiology data are reported to health authorities. This has the effect of providing the local health departments with better information and brings to examination and treatment, if infected, a greater number of persons who, otherwise, may continue to spread their infection.

3. Enclosure (1) has been prepared to assist in more prompt routing of all contact reports. The prime consideration in routing is to forward reports as soon as possible to the city or state wherein the contact can most likely be found. The use of air mail should be considered where at least one day can be saved in initiating contact investigation over transmission by ordinary mail. Enclosure (1) replaces reference (a); the instructions for preparation and routing as contained on the reverse of NAVMED-171 (reference (b)); and pages 27-30 of reference (c). These instructions will be incorporated in chapter 23, for the 1949 edition of the Manual of the Medical Department, and in reference (c) when revised.

4. In order to improve the venereal disease contact reporting and investigation system, it is requested that particular attention be given to:

a. Securing the names, addresses, and other helpful information on all contacts for that period of time in which the infected individual could have acquired or transmitted his infection.

b. Prompt preparation and routing of contact reports.

c. Completion of physical examination and return of reports on military contacts of infected civilians when reported by health authorities.

C. A. Swanson

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BUMED CIRCULAR LETTER 50-32

6 April 1950

From: Chief, Bureau of Medicine and Surgery  
To: All U. S. Navy and Marine Corps Recruiting Stations  
Subj: Antihistamine Drugs

1. It is noted that many recruiting activities are procuring by open purchase proprietary antihistaminic drugs.

2. Catalog of Medical Materiel items 1-489-000 Tripelennamine Hydrochloride and 1-168-350 Diphenhydramine Hydrochloride will be used in lieu of proprietary antihistamine drugs where it is believed such medication is indicated.

C. A. Swanson

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BUMED CIRCULAR LETTER 50-33

10 April 1950

From: Chief, Bureau of Medicine and Surgery  
To: All Naval Hospitals

Subj: Joint Statement of Policy on the Release of Information from  
Medical Records of Members and Former Members of the  
Armed Forces

Encl: (1) Copy of SECNAV ltr of 14 Mar 1950 to BuMed

1. Enclosure 1 is forwarded for information and compliance. C. A. Swanson

Enclosure (1)

From: The Secretary of the Navy  
To: Chief, Bureau of Medicine and Surgery

14 March 1950

Subj: Joint Statement of Policy on the Release of Information from  
Medical Records of Members and Former Members of the  
Armed Forces

1. The joint policy on release of information from medical records of members and former members of the armed forces has been restated.
2. The release of medical information, only under confidential classification, by those bureaus and offices designated by me will be governed by the policy restated as follows:

COMPLETE TRANSCRIPT OF MEDICAL RECORDS ON REQUEST

- a. Department of the Army
- b. Department of the Navy
- c. Department of the Air Force
- d. Department of the Treasury (Coast Guard)
- e. Department of Commerce (Coast and Geodetic Survey)
- f. Federal Security Agency (Public Health Service)
- g. The Veterans Administration
- h. Selective Service
- i. Federal or State hospitals or penal institutions when the member or former member is a patient or inmate therein.
- j. Registered civilian physicians, upon request of the individual or his legal representative, when required in connection with the treatment of the member or former member of the above services.
- k. The member or former member himself upon request, except information contained in the medical record which would prove injurious to his physical or mental health. (See Public Law 681, 77th Congress, approved 28 July 1942).

1. The next of kin on request of the individual, or legal representative, when under the provisions of Public Law 681 the information may not be disclosed to the veteran himself; and directly to the next of kin, or legal representative, when the member or former member has been adjudged insane or dead.

m. Duly accredited representatives of the National Academy of Sciences-National Research Council, when engaged in cooperative studies undertaken at the specific request or with the consent of the Surgeon General, U. S. Army, the Surgeon General, U. S. Navy, or the Surgeon General, U. S. Air Force.

PARTIAL TRANSCRIPT OF PERTINENT INFORMATION FROM  
MEDICAL RECORDS ON REQUEST

- a. Department of Justice
- b. Department of the Treasury (except Coast Guard)
- c. The Post Office Department

(Each request will be made in connection with the investigations conducted by the above-named Departments and will be considered on its merits. The information released will be the minimum necessary.)

3. Nothing in this statement of policy is intended to preclude the release of appropriate information concerning the current health and welfare of the individuals in the armed services, or vital statistical data, including proof of death, concerning such personnel, nor to preclude compliance with court orders calling for the production of medical records in connection with litigation or criminal prosecutions.

4. The Bureau of Medicine and Surgery, through the Surgeon General and Chief of Bureau, and through the commanding officers of naval hospitals in cases of records physically located therein, is redesignated as the Bureau responsible for the execution of this policy in the release of such medical records.

5. Articles 1250-1252 and 1509-1510, U. S. Navy Regulations 1948, Appendix C15-C16, Naval Courts and Boards, Paragraph 12B11.3 (a), Manual of the Medical Department 1945, ALNAVSTA 132051 of 13 March, 1942, and Chapter VI, Title 34, Part 701, Code of Federal Regulations (Federal Register, Part II, Volume 13, Number 252, of 28 December 1948), provide necessary implementation for continued application of this joint policy to release by the designated Bureau of all medical records.

/s/ Dan A. Kimball  
Under Secretary of the Navy

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BUMED CIRCULAR LETTER 50-34

12 April 1950

From: Chief, Bureau of Medicine and Surgery  
To: Commanding Officers, U. S. Naval Hospitals

Subj: Review of Recurring Reports

Refs: (a) SecDef memo of 18 Feb 1950, Subj: Effecting economies in reporting  
(b) SecNav ltr of 3 Mar 1950, Subj: Review and justification of recurring reports

Encl: (1) Procedures for Review of Recurring Reports

In order for BuMed to report to SecNav in accordance with references (a) and (b), this letter directs addressees to establish screening committees as outlined in the enclosure to make a comprehensive review of all internal reports and submit to BuMed not later than 26 June 1950, a summary report of accomplishment as outlined in the enclosure.

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NAVY DEPARTMENT  
BUREAU OF MEDICINE AND SURGERY  
WASHINGTON 25, D. C.

OFFICIAL BUSINESS

Permit No. 1048  
NavMed-369 - 4 /50

PENALTY FOR PRIVATE USE TO AVOID  
PAYMENT OF POSTAGE. \$300